UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

Trust Board Bulletin – 7 April 2011

The following reports are attached to this Bulletin as items for noting, and are circulated to UHL Trust Board members and recipients of public Trust Board papers accordingly:-

- **Briefing report on cancer 2-week waits performance.** Lead contact point – Mrs S Hinchliffe, Chief Operating Officer/Chief Nurse (0116 258 5488) – **paper 1**;

- **Annual update on Trust Board declarations of interests (2011-12).** Lead contact point – Mr S Ward, Director of Corporate and Legal Affairs (0116 258 8615) – **paper 2**;

- **Report on Leicestershire County Council Health and Wellbeing Board.** Lead contact point – Mr M Wightman, Director of Communications and External Relations (0116 258 8615) – **paper 3**.

It is intended that these papers will not be discussed at the formal Trust Board meeting on 7 April 2011, unless members wish to raise specific points on the reports.

This approach was agreed by the Trust Board on 10 June 2004 (point 7 of paper Q). Any queries should be directed to the specified lead contact point in the first instance. In the event of any further outstanding issues, these may be raised at the Trust Board meeting with the prior agreement of the Chairman.

Trust Board Bulletin 7 April 2011 – paper 1

To:	**Trust Board**
From:	**Suzanne Hinchliffe**
Date:	7 April 2011
CQC regulation:	All applicable

Title:	CANCER 2 WEEK WAIT (2WW)

Responsible Director: Suzanne Hinchliffe, Chief Operating Officer / Chief Nurse
Author: Charlie Carr, Head of Performance Improvement

Purpose of the Report:
-To understand the impact on the Trust's ability to achieve the 2ww standard where patients choose to wait longer than 14 days for their 1st attendance
-To provide assurance to the Board that mitigating actions are in place to ensure that patients are made aware of the urgency of their appointments and they are given appropriate information to support any decisions they may make to wait longer.

The Report is provided to the Board for:

Decision		Discussion	X
Assurance	X	Endorsement	

Summary / Key Points:

- There are a number of key issues associated with patients being fully informed at the point of referral which inhibits timely delivery of 1st appointments
- A number of clear actions have been taken and others are in the process of being implemented that will mitigate against further poor performance.

Recommendations:
That the Board note the content of this paper and endorse the actions detailed.

Strategic Risk Register **-**	**Performance KPIs year to date** CQC

Resource Implications (eg Financial, HR)

NA

Assurance Implications

NA

Patient and Public Involvement (PPI) Implications
To be determined

Equality Impact
NA

Information exempt from Disclosure
NA

Requirement for further review ?
Monthly cancer performance

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **7th APRIL 2011**

REPORT BY: **SUZANNE HINCHLIFFE, CHIEF OPERATING OFFICER / CHIEF NURSE**

REPORT AUTHOR: **CHARLIE CARR, HEAD OF PERFORMANCE IMPROVEMENT**

SUBJECT: **CANCER 2 WEEK WAIT (2WW)**

1.0 Introduction

This paper describes the processes by which the appointments for this standard are dealt with within the Trust. The tolerance in the target of 93% is in place to allow for patients who choose to wait longer than 14 days for their 1st attendance.

UHL in common with other Trusts experiences increased pressure to meet the standard where patients are unaware of the clinical urgency of the reason for their referral and are not available within the 14 day standard or where they initially agree to a date within 14 days but subsequently cancel their agreed appointment and no further dates are available within the 14 day window.

The number of patients who Did Not Attend (DNA) account for a small but not insignificant number. Although this does not present a problem to the Trust in terms of achieving the 2ww standard for individual patients, as a DNA of a 1st appointment resets the waiting time, every DNA is wasted capacity, which could have been used for another patient.

2.0 Current performance

Target: 93% of all patients referred for suspected cancer to be seen within 2 weeks of referral.
January 2011 88.5%
February 2011 95.7%

3.0 2 week wait process

Referrals are received into the Trust via the central 2 week office. Referrals are administratively triaged against key criteria, which have been clinically agreed by both primary and secondary care. The outcomes of this triaging process determine the type of 1st attendance at UHL. This may be an outpatient appointment, endoscopy or a diagnostic imaging appointment.

Outpatient appointments are generally directly booked by the 2ww office staff. Requests for endoscopy and imaging are faxed to the departments who are responsible for booking appropriate appointments and communicating with patients. Wherever possible, all patients are contacted by phone and dates agreed. This is confirmed in a letter to the patient and the GP receives a confirmation that an appropriate booking has been made.
Tracking of patients is initiated by the 2ww office and progressed by cancer tracking and coordinating staff.

3.1 Issues

i) Where a GP has made it clear at the point of referral that a patient is not available during the 2 week period, the 2ww office return referrals to GP's, requesting that patients are referred when they are available.
ii) Many patients are unaware of the urgency of their referral and it is clear that GP's do not routinely advise them that they are referring them to exclude a cancer diagnosis.
iii) Patients who are contacted by UHL with an appointment may choose to wait longer that 14 days. During January this accounted for approximately 9% of the breaches of the standard.
iv) It is not uncommon for patients who are offered and initially accept a date within 2 weeks to subsequently cancel and wish to re book. Reports from administrative teams often indicate that patients are not aware of the urgency. Due to the limited timeframe this causes significant issues with the Trust being able to rebook within the original 14 day period. During January this accounted for approximately 25% of the breaches.
vii) Patients choosing to delay their initial 2ww appointment or any subsequent appointments on their cancer diagnostic pathway causes a knock on impact to achievement of the 62 day target (from initial referral to treatment)
viii) The Did Not Attends, (DNA's) rate is approximately 4%. (See section 5.1)

4.0 How other Trusts are managing the 2ww process

In order to learn how other Trusts are consistently achieving the 2ww standard we have targeted those who have similar volumes of 2ww patients and have asked direct questions relating to their policies, standards and processes. All report consistent messages of:-

- variability of patient knowledge of the fact that they have been referred to a cancer exclusion service, despite reiteration to GPs of the importance of doing so.
- the requirement for very tight administrative processes and early escalation of capacity issues.
- policy practiced in line with the Department of Health (Going Further With Cancer)

The achievement of 99% against this target by some of these Trusts does suggest variability of application of national policy.

5.0 Actions already taken and or in progress within UHL

No	Issue	Mitigating action	Effect	Timeframe
1	Patients not aware of urgency	- all GP practices have electronic copy of patient 2ww leaflet and have been asked to give this to all patients referred - all UHL departments booking 2ww appointments now sending out this leaflet with appointment confirmations (see Appendix A) - all UHL 2ww appointment letters to be standardised with key message of urgency - all phone contact with patients by UHL staff to include standard telephone script (see section 5.1)	Patient more likely to make themselves available within 14 days and to attend booked appointments	Immediate
2	At point of referral GP has made it clear that patient is not available within 14 days	- GP is advised that patient should be referred when they are available and will be seen within 2 week period - Where GP insistent that UHL takes responsibility for patient, waiting time to start from point of patient availability	Patient safety will be maintained Will not breach 2ww target	Immediate
3	Patient initially booked a date within 14 days but contacts UHL and wants to wait longer	- All patients to receive 2ww leaflet - At point of phone call, standard script to be used to stress urgency of need to attend booked appointment - If patient insistent that they delay appointment, every attempt to be made to book within original 14 days, if this is not possible this is a breach due to patient choice.	Patient more likely to make themselves available within 14 days and to attend booked appointments	Immediate
4	Incorrect or missing referral details from General Practice	- GP practice to be contacted immediately by 2ww office - Waiting time to be reset until adequate referral information received	No patient will breach 2ww standard due to avoidable administrative delays	Immediate
5	Patient DNA's appointment	- Actions detailed above aim to minimise DNA's - Tumour sites with higher rate of DNA to do reminder phone calls to patients - DNA's of 1st appointment the waiting time resets - X2 DNA's of 1st appointment and patients are discharged back to their GP	All patients clear about the urgency of their referral, intention to reduce DNA's and maximise existing capacity	Immediate

5.1 Additional actions

- A review of the Trust's appointment letters sent to patients revealed that the sense of urgency was not conveyed. The wording is being standardised for all 2ww letters and will read:-

'Dear Patient
Your GP has requested an URGENT appointment for you to be seen within 2 weeks. As this is only short period of time it is very important that you make every effort to attend your appointment'

This with the accompanying 2ww leaflet (Appendix A) gives a clear and objective message which may not have been conveyed by the GP.

- A standardised telephone script is being issued to all staff who receive phone calls from patients wishing to cancel and rebook appointments urging patients to attend 2ww appointments but not requiring unqualified staff to discuss clinical issues.
- A small sample of 4 of patients (10%) who DNA'd in January, but whom subsequently attended and were diagnosed as non cancers were contacted by phone to understand the reason for their non attendance at 1st appointment. 2 advised they were not informed of the urgency by their GP at point of referral and had personal reasons for non attendance. 2 advised that they were clearly told of the urgency for referral, of these 1 had chosen to change their appointment on the day, the other had been notified of the appointment too late to attend that day.
- Initial discussion with UHL Communications about feasibility of further local publicity about 2ww services
- Collaborative Clinical Interface Group (CCIG) requested to re iterate to GPs the importance of informing all patients referred to 2ww services of reason for referral and the importance of attendance at all booked appointments

University Hospitals of Leicester NHS
NHS Trust

NHS
Leicester City

NHS
Leicestershire County and Rutland

Why have I been referred urgently to the hospital?

(The urgent two-week wait referral system)

Why have I been referred to hospital?

Your doctor/general practitioner (GP) or dentist has asked for you to have an urgent hospital appointment within two weeks. The 'two-week' appointment system is there so that any patient with symptoms that might indicate cancer can be seen by a specialist as quickly as possible.

Does this mean I have cancer?

No, it doesn't. The majority of patients referred under the 'two-week' appointment system do not have cancer, but a simple or benign condition. Your referral may be necessary for a number of reasons:

- your symptoms need further investigation,
- the treatment already prescribed has not been effective,
- investigations your GP arranged have shown some abnormal results,
- to exclude serious disease.

However, it is important that we identify what is causing your problems quickly to start any necessary treatment as soon as possible and to put your mind at rest. So it is essential that you attend the earliest appointment offered to you.

Will I need any tests?

You may require specialised tests; these may take place either before or during your first appointment at the hospital. You may also require more than one test before seeing a specialist. This will help the specialist understand the cause of your symptoms.

What do I need to do now?

- Once you have agreed an appointment at the hospital, ensure that you follow instructions and attend on the date agreed.
- At your first appointment, based on the information from your GP and your consultation with the hospital, you will be given more information about what will happen next. If you have any worries or questions before your hospital appointment your GP will be happy to talk to you
- You can bring someone with you to this appointment as you may find this helpful.
- You might want to write down some questions to ask at the appointment and also write down the answers you are given.

Your right to an appointment within two weeks

As part of the *NHS Constitution* you have a right to an appointment at the hospital within two weeks - either for a test or with a specialist, whichever is most appropriate. If you are experiencing difficulty getting an appointment, then please contact The University Hospitals of Leicester NHS Trust , Two Week Wait Office on 0116 2502543 or if your enquiry is about a breast appointment on 0116 2583751

It is important to remember that an urgent two-week wait referral does not necessarily mean that you have cancer but it is important you attend within the two weeks

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **7 APRIL 2011**

REPORT BY: **DIRECTOR OF CORPORATE AND LEGAL AFFAIRS**

SUBJECT: **DECLARATIONS OF INTERESTS – ANNUAL UPDATE (2011-12)**

Proformas for the annual update of Trust Board declarations of interests have been circulated to all Trust Board members, and also to the Director of Strategy, Director of Communications and External Relations, and Director of Corporate and Legal Affairs. Details received to date are set out below.

The Trust Board is invited to receive and note this report.

NAME	POSITION	INTEREST(S) DECLARED
Mr M Hindle	Trust Chairman	Board member, Health Protection Agency, and Chair of its Finance Committee. Son is a partner in Beachcroft LLP, who provide legal advice to the Trust (not directly involved).
Mrs K Jenkins	Non-Executive Director	Employee of Egg Banking plc (which is a part of Citigroup).
Mr R Kilner	Non-Executive Director	Director of Deltex Consulting Ltd; Member of the Patient Group for Countesthorpe Health Centre.
Mr P Panchal	Non-Executive Director	Board member of the Akwaaba Ayeh Mental Health Project; Company Secretary of the Leicestershire Ethnic Minority Partnership Ltd (charity).
Mr I Reid	Non-Executive Director	Poppy Day Collector for the Royal British Legion; Trustee of Bitteswell United Charities.
Mr D Tracy	Non-Executive Director	Lay member and Chairman elect of the Insolvency Practices Council.
Ms J Wilson	Non-Executive Director	Board Chair, Leicestershire and Rutland Probation Trust.
Professor D Wynford-Thomas	Non-Executive Director	Trustee, Hope Against Cancer (cancer charity, Leicester); Dean of the University of Leicester Medical School and Pro-Vice Chancellor, Head of

NAME	POSITION	INTEREST(S) DECLARED
		College for Medicine, Biosciences and Psychology, University of Leicester.
Mr M Lowe-Lauri	Chief Executive	Trustee, Thomas Cook Children's Charity; Member, NIHR Advisory Board; Member, Life Science Innovation Delivery Board; Member, HEFCE Health Education Advisory Committee; Member, Kings Fund Advisory Board Member, Strategic Advisory Board, Loughborough University; Chair, East Midlands Collaboration in Management Sciences; Chair, Kings College Hospital Scientific Advisory Board PSSQ; Chair, NIHR Industry Forum Chair, NIHR/Wellcom HICF
Ms K Bradley	Director of Human Resources	None to declare
Dr K Harris	Medical Director	None to declare
Mrs S Hinchliffe	Chief Operating Officer/Chief Nurse	None to declare
Mrs A Tierney	Director of Strategy	None to declare
Mr A Seddon	Director of Finance and Procurement	Spouse is an Equity Partner in Morgan Cole Solicitors, who conduct work for the NHS.
Mr S Ward	Director of Corporate and Legal Affairs (post acts as adviser to the Board as of January 2007)	None to declare
Mr M Wightman	Director of Communications and External Relations (post acts as adviser to the Board as of January 2007)	None to declare

Stephen Ward
Director of Corporate and Legal Affairs

To:	**Trust Board**
From:	Director of Communications and External Relations
Date:	**7 April 2011**
CQC regulation:	All that apply

Title:	**The formation of a Health and Well being Board for Leicestershire County**

Author/Responsible Director: Mark Wightman / Cheryl Davenport (Programme Director NHS Leicestershire County & Rutland/ Leicestershire County Council)

Purpose of the Report: For Information within the Trust Board Bulletin

The Report is provided to the Board for:

Decision		Discussion	
Assurance		Endorsement	

Summary / Key Points: The NHS White Paper "*Liberating the NHS: Equity and Excellence*" (July 2010) set out radical reforms with the abolition of primary care trusts by 2013, a new commissioning landscape, new partnerships, and new roles and responsibilities, including the introduction of GP consortia (as majority commissioners of NHS services), and the transfer of public health responsibilities into local authorities. The supporting publication, "*Liberating the NHS: Local democratic legitimacy in health*" describes specific responsibilities for local authorities in the new system.

This report focuses on the role of local authorities to establish Health and Wellbeing Boards, the purpose and terms of reference of these boards and how locally they are responding to this requirement in Leicestershire.

Recommendations:
The Board is asked to note this paper as part of the Trust Board Bulletin and refer any questions to Mark Wightman.

Strategic Risk Register	**Performance KPIs year to date**

Resource Implications (eg Financial, HR)

Assurance Implications

Patient and Public Involvement (PPI) Implications

Equality Impact

Information exempt from Disclosure

Requirement for further review ?

What is the purpose of a Health and Wellbeing Board?

The primary purpose of a Health and Wellbeing Board, as defined in the NHS White Paper and subsequently the Health and Social Care Bill, is to:

- Promote integration and partnership working between the NHS, social care, public health and other local services; and
- Improve local democratic accountability.

Who will be on the Board?

The membership of the Board in shadow form will essentially follow the statutory membership proposed within the legislation. The focus is on having a small core group comprising local commissioning leaders, recognising that NHS commissioning in the future is to be clinically led with strong democratic accountability.

For Leicestershire this means:

- The Cabinet Lead Member for Health
- The Cabinet Lead Member for Adults and Communities
- The Cabinet Lead Member for Children and Young People's Services
- At least one representative of each of the GP Consortia within the local authority area
- The Director of Public Health
- The Director of Adults and Communities
- The Director of Children and Young People's Service
- LINk Representation – two places (to be replaced by Local Health Watch representation, when established)
- The Chief Executive of NHS LCR, the local Primary Care Trust. This place could be allocated to a representative of the National Commissioning Board when this is established.
- Local Medical Committee representation – one place
- District Council representation – two places. Representation will be sought from the District Councils after the elections in May 2011.

Role of the Lead Member for Health

In recognition of the Council's new role and responsibilities within health (including public health), a new lead member role has been created in Leicestershire. Mr E F White CC has been appointed to lead this portfolio, which will include becoming Chairman of the Health and Wellbeing Board. (Note to UHL Board: Cllr. Ernie White is also the County Council's representative on our Council of Governors)

What will the Board actually do, and what is its status and statutory functions?

The Department of Health publication *Liberating the NHS: Next Steps and Legislative Framework* (Dec 2010), indicated that Health and Wellbeing Boards will be mandatory for each upper tier authority, constituted in governance terms as a statutory committee of the local authority and that partners would have a duty to participate in the Board, acting in partnership to discharge its functions.

The Health and Wellbeing Board will be a unique body in governance terms, when it becomes statutory and is constituted as a County Council committee with executive powers. This is due to the membership being drawn from different sectors and, in the case of the County Council, from both officers and members.

It is intended the Board will be the main vehicle for key commissioning partners from both health and social care, elected members and representatives of the public to come together to:

- Assess local needs and inequalities
- Promote health and wellbeing
- Drive the delivery of improved outcomes for the population's health and well being, across the system of care (e.g. across public health, social care and NHS services) and provide improved integration of services provision
- Play a critical role in local strategic leadership for commissioning, with the Board providing one of the main "cogs" in the new system for health services envisaged in the white paper.

It is through the work of the Board that elected members, local authority and NHS commissioners and local stakeholders will shape and influence:

- The individual commissioning plans of NHS commissioners such as the emerging GP consortia and NHS National Commissioning Board (when established).
- The individual commissioning plans of local authorities for improving population level health and wellbeing, reducing inequalities and improving care services for adults, children and vulnerable people.
- The opportunities to develop improved joint commissioning arrangements across local agencies and budgets, to achieve shared outcomes.

The Health and Social Care Bill currently before Parliament has defined the proposed statutory obligations on the Board and its members.

In particular the legislation states GP Consortia and Local Authorities, through the Health and Wellbeing Board, will be jointly responsible for the production and publication of a Joint Strategic Needs Assessment (JSNA), and a Joint Health and Wellbeing Strategy for the local population.

The Board will also be expected to provide assurance that commissioners across the system provide evidence of how these products have informed their commissioning plans and decisions, and how their plans will contribute to achieving the aims of the Health and Wellbeing Strategy for their population.

What is the process and timetable for setting up the Health and Wellbeing Board in Leicestershire and how is this being co-ordinated?

The implementation of the Health and Wellbeing Board is one of 6 elements of work being governed by the Joint Change Programme Board.

This executive level board is directing the local authority's transitional work associated with the NHS White Paper and the Health and Social Care Bill. The Joint Change Programme Board is comprised of representatives from the local authority, the PCT and latterly GP consortia leaders. A sub group is focused on the implementation of the Health and Wellbeing Board.

The aim is for the Leicestershire Health and Wellbeing Board to meet in its shadow form starting from April 2011.

The implementation plan and terms of reference recognise the progress of NHS reforms through the shadow period, the timing in October 2011 of legislation leading to the statutory constitution of the Board, and the implications of other changes in the NHS system, some of which will not be finalised in full until April 2013.

What does it mean to be an early implementer?

The County Council is participating as one of the Department of Health early implementer sites for Health and Wellbeing Boards. The Council is working with other communities who are doing the same work at the same time, to share good practice and ideas with each other and the Department of Health.

In accordance with the reform timetable nationally, every upper tier authority must have a shadow board in place by April 2012, but the County Council will be one of the first in the country to do this by April 2011.

Leicestershire County Council's profile in this work is already very strong. It is seen as leading the way by making good progress on reform preparations locally, and as a result the Council and NHS LCR are actively shaping national thinking about the approach to implementation for Health and Wellbeing Boards, which will benefit other communities that follow.

By implementing the new way of working early, Leicestershire can focus the Board at an early stage on the task of improving outcomes collectively for local people, help members of the Board engage early in their new roles, and maintain momentum on important developments already in progress.

Next Steps

Terms of reference for the board are being presented to the Council's Cabinet meeting and the PCT's Trust Board meeting for approval on April 5th and 14th respectively.

A workshop is planned on 19th April to prepare the proposed Health and Wellbeing Board members for their new role and responsibilities, with the first meeting of the Shadow Board taking place on 26th April.

There is a proactive communication and engagement plan already in progress with a wide variety of stakeholders, including within the Leicestershire Together partnership where a number of other developments are taking place alongside the introduction of the new Health and Wellbeing Board.

A workshop is also proposed for stakeholders of the Board in late May. This will explain how the Board proposes to engage with the Leicestershire Together partnership and with other stakeholders across the community.

ENDS